

In The United States District Court
Western District of Arkansas
Fayetteville Division

FILED
US DISTRICT COURT
WESTERN DISTRICT
OF ARKANSAS
Sep 11, 2018
OFFICE OF THE CLERK

FRANK CARMONA RODRIGUEZ

Plaintiff

v.

Deputy Torres,
Sheriff Holloway,
Captain Guffy,
JOHN & JANE DOE(S)

Case no: 5:18cv05118

5:18cv05118

U.S. Clerk's Office

JUN 15 2018

Received WDAIR

~~Frank Carmona Rodriguez~~, TURN KEY Medical, et al

Defendants

42 USC § 1983 Complaint

Amended Complaint #1

On May 2, 2018 I WAS subjected
To Deliberate Indifference AND EXCESSIVE
FORCE by Defendant, Deputy IVAN TORRES.

During pit call I ASKED [TORRES] FOR THE
NEWSPAPER. HE SAID NO TO ME, but gave it
to ANOTHER DETAINEE, I TOLD [TORRES] IN
SPANISH THAT HE WAS PREJUDICE.

[TORRES] THEN TOLD ME TO COME TO HIM, WHICH
I DID [TORRES] THEN SLAMMED ME AGAINST
THE BLOCK WALL OF POD CONTROL

Amended

[TORRES] THEN TWISTED MY LEFT HAND, WRIST, AND ELBOW VERY HARD AND FORCEFUL. WITH DELIBERATE INDIFFERENCE TO MY 61 YEARS OF AGE OR THE FACT THAT I WAS NON-COMBATANT, COMPLIANT.

[TORRES] JAMMED THE CUFFS ONTO MY WRISTS SO TIGHT I YELLED OUT IN PAIN.

THE PAIN WAS SO BAD I HAD TO RAISE MY LEFT ARM/HAND AND HOLD IT TO EASE THE PAIN. I AM STILL SUFFERING PAIN AND PERMANENT SWELLING AND A KNOT ON MY LEFT WRIST FROM THIS.

Amended Complaint # 2

THE CONDITIONS OF CONFINEMENT AT THE BCDC UNCONSTITUTIONAL THE FOLLOWING ARE ISSUES @ THE BCDC.

I HAVE SUFFERED BY BEING HOUSED IN AN OVER-CROWDED POD/CELL 3 MEN ARE HOUSED IN A 2 MAN CELL FOR AT TIMES 15 HOURS PER DAY.

THERE ARE NO WORKING T.B. LIGHTS, VENTILATION SYSTEM IS DIRTY AIR SMELLS BAD.

Amended Complaint #2 Continued
THE NOISE LEVELS BECAUSE OF THE OVER-
CROWDING AND LACK OF SOUND DEADENING
ON THE WALLS BECOMES PAINFUL DELIBERATE
INTOLERANCE IS SHOWN BY BCDC STAFF
TO THE NOISE LEVELS

THE SUPERVISORS OF [IVAN TORRES]
FAILED TO PROPERLY TRAIN & SUPERVISE
[TORRES]. HAD PROPER TRAINING AND SUPERVISION
BEEN GIVEN [TORRES] WOULD HAVE KNOWN
NOT TO LET HIS FEELINGS GET IN THE WAY
OF HIS JOB OR TO USE SUCH FORCE,
AS WAS USED AGAINST ME A 61 YEAR OLD
NON-VIOLENT INMATE

PROPER TRAINING AND SUPERVISION WOULD
HAVE PREVENTED MY INJURY
DELIBERATE INTOLERANCE TOWARD THE
PAST VIOLENT HISTORY OF DEPUTY [TORRES]
HAS ALLOWED HIS [TORRES] ACTIONS TO
GO UNCHECKED

Amended Complaint # 4

TURN KEY MEDICAL

SHOWED DELIBERATE INDIFFERENCE TO MY MEDICAL CONDITION CAUSED BY [TORRES] MAY 2ND 2018. I WAS IN PAIN FOR 10 DAYS BEFORE BEING SEEN BY MEDICAL. NURSE INFANTE TOOK A PHOTO OF MY WRIST, NEXT DAY AN X-RAY WAS TAKEN. MY WRIST IS STILL SWOLLEN AND I HAVE SEVERE PAIN AS OF JUNE 5, 2018.

I RECEIVE NO PAIN MEDS AND A LARGE KNOT HAS FORMED ON MY LEFT WRIST THAT HURTS.

DELIBERATE INDIFFERENCE IS BEING SHOWN BY [TURN KEY] AS TO MY PAINFUL CONDITION. NO MRI WAS TAKEN. NO PAIN MEDICATION HAS EVER BEEN GIVEN.

I AM STILL IN PAIN FROM THIS INJURY. MY WRIST IS STILL DEFORMED, KNOTTED, AND DISFIGURED.

DELIBERATE INDIFFERENCE IS BEING SHOWN BY [TURN KEY] TOWARD MY INJURY AS IT IS EXPENSIVE & TROUBLESOME FOR AN MRI TO BE TAKEN.

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF ARKANSAS
FAYETTEVILLE DIVISION

FRANK CARMONA RODRIGUEZ

PLAINTIFF

VS.

CASE NO. 5:18-CV-05118-TLB-ELW

DEPUTY IVAN TORRES; ET AL.

DEFENDANTS

**INTERROGATORIES AND REQUESTS FOR PRODUCTION
OF DOCUMENTS PROPOUNDED TO PLAINTIFF
ON BEHALF OF SEPARATE DEFENDANT, TURN KEY HEALTH CLINICS, LLC**

Comes Separate Defendant, Turn Key Health Clinics, LLC, by and through their attorneys, Mitchell, Williams, Selig, Gates & Woodyard, PLLC, and propound the following written discovery upon Plaintiff:

INTERROGATORY NO. 1: Please state the name of the person(s) providing the information responsive to these Interrogatories and for each such person state:

- (a) full name, age and address; *Frank Carmona Rodriguez*
- (b) ADC Inmate Number (if applicable); *1300 S.E. 14th St.*
- (c) Social Security number; and *40093*
- (d) any other name by which the person has ever been known. *objection*

INTERROGATORY NO. 2: With regard to your education history, please state the following:

- (a) the extent of your formal education; *GED*
- (b) the name of the high school attended and date of graduation; and *Raton N.M. High School 1975*
- (c) name of college or university, including years attended, date of graduation and any degrees obtained. *—*

INTERROGATORY NO. 3: Please state whether you have ever been a party to a lawsuit, whether domestic, civil, criminal and/or an administrative proceeding. If so, please state

the following:

Never

- (a) the style of the lawsuit, including the name of the court and docket number;
- (b) the date the lawsuit or proceeding was filed;
- (c) the subject matter of the lawsuit; and
- (d) the ultimate disposition of the case.

INTERROGATORY NO. 4:

Please state in detail the nature, extent and duration

of any and all injuries suffered by Plaintiff which you claim to be the result of a constitutional violation by Turn Key Health Clinics, LLC. *on going*

INTERROGATORY NO. 5:

Please state and itemize the amount of all special

damages (medical bills or other money damages for which you have been or will be billed)

sought by you as a result of the actions alleged in the Complaint and Amended Complaint,

including, but not limited to, doctor bills, hospital bills, drug bills, and all others.

\$3,500.00

INTERROGATORY NO. 6:

Please state whether you ever suffered any illness or

medical condition that resulted in a lasting disability, hospital stay or physical problem prior to

the events which are the subject of this lawsuit. If your answer is yes, please describe each

disability and physical problem, or if a hospitalization, the name of the hospital, time you were in

the hospital, and reason you were in the hospital.

wrist still impaired

INTERROGATORY NO. 7:

Please state whether you have seen any physicians,

counselors, psychiatrists, psychologists, or other medical care providers for any reason that you

attribute to the incident described in your Complaint and Amended Complaint. If your answer is

yes, please provide a complete description of each visit, date of each visit, name and location of

the medical care provider seen, and any records in support of each visit.

None

INTERROGATORY NO. 8:

Please give the name and address of each doctor,

hospital or doctor's office where you received medical treatment for any of the damages that you are seeking to recover for in this lawsuit.

INTERROGATORY NO. 9: Have any funds been expended by Medicare/Medicaid on your behalf in connection with any of the injuries alleged in the Complaint and Amended Complaint? If so, please itemize to whom and in what amount Medicare/Medicaid has made any such payments.

INTERROGATORY NO. 10: Please state whether a claim has been made for benefits under any insurance policy or against any person, firm, or corporation for personal injuries or a physical condition you have not heretofore listed in your answers to these discovery requests. If your answer is yes, please provide the following information:

- (a) full name and address of each person, firm or corporation to whom or against whom, the claim was made;
- (b) date each claim was made;
- (c) type of compensation received for each claim; and
- (d) amount of compensation for each claim.

INTERROGATORY NO. 11: Please state the name, address and telephone number of each and every individual known to you who has personal knowledge of any facts which support the allegations of:

- (a) constitutional violations by Turn Key Health Clinics, LLC; and
- (b) *failure to treat & pain & suffering*
damages suffered by you.

INTERROGATORY NO. 12: Please state the name, address and telephone number of each and every individual who you intend to call as a lay witness at the trial of this matter. *unknown @ this time*

INTERROGATORY NO. 13: Please state the name, address and telephone

number of any individual who will be called as an expert witness on your behalf at trial.

INTERROGATORY NO. 14: For each expert witness identified in response to the previous interrogatory, please state the following: *SEE ANSWER # 12*

- (a) their education, licenses and certificates, and career history (or, in the alternative, attach a copy of their most recent *curriculum vitae*);
- (b) the date, title and subject matter of all of their publications or other medical or professional articles whether published or unpublished (or, in the alternative, attach a copy of their most recent list of publications and other writings);
- (c) whether the expert has ever been sought to be qualified as an expert in any prior judicial or administrative proceeding, and, if so, please state the name of the case, the name of the court, and the subject matter of any such proceeding;
- (d) whether the expert has ever testified as an expert, whether orally or in writing (including depositions), in any judicial proceeding, and if so, please state the name of the case, the name of the court, and the subject matter of the proceeding; and
- (e) a copy of any invoices submitted by said expert to you or your lawyer.

INTERROGATORY NO. 15: Please state and list by page, author and publisher all medical literature to be relied upon by any expert witness testifying on your behalf in the presentation of this case. *SEE ANSWER # 12*

INTERROGATORY NO. 16: With respect to the allegations contained in the Complaint and Amended Complaint, and any expert witnesses anticipated to be called in support thereof, please state the following:

- (a) the subject matter on which they are expected to testify;
- (b) the substance of the facts and opinions to which they are expected to testify, and a summary of the grounds for each opinion so described;
- (c) the identity of all documents that have been provided to them or that they have received in connection with their expected testimony;
- (d) the identity of all reports, schedules, photographs, charts, diagrams, work papers, or other documents they have prepared or that they have been prepared for them

in connection with this proceeding, and attach copies of all such documents to your answers; and

- (e) the date and subject matter of all communications that they have had with any party to this action (including Plaintiff), the identity of the party with whom they have communicated and the identity of all documents relating to such communications.

SEE ANSWER # 12

INTERROGATORY NO. 17: Please state the name and address of all physicians

who have provided medical care to you in the last ten years.

INTERROGATORY NO. 18: Please state the name and address of all hospitals or

medical facilities where you were admitted for treatment on either an outpatient or inpatient basis in the last ten years.

INTERROGATORY NO. 19: Please list and describe each and every chart, graph,

document, exhibit and/or any type of physical or tangible evidence which will be displayed or introduced at trial, and for each such item, please state the name and address of the person or company in possession of that item. *DISCOVERY INcomplete*

INTERROGATORY NO. 20: Please list the name, address and specialty of any

physician or other medical care provider with whom you have consulted who supports the allegations against Turn Key Health Clinics, LLC, described in your Complaint and Amended Complaint, state the date such individual was first consulted, and provide a summary of his/her opinions. *SEE ANSWER # 12*

INTERROGATORY NO. 21: Please list the name, address and specialty of any

physician or other medical care provider with whom you have consulted who supports the allegation that any alleged acts by Turn Key Health Clinics, LLC, was a proximate cause of injury to you, including the date of consultation and a summary of opinions. *SEE # 12*

INTERROGATORY NO. 22: Please identify all of the correctional facilities

where you have been incarcerated, including the periods of incarceration for each facility, and the crime for which you have been incarcerated each time. *Objection*

INTERROGATORY NO. 23: Please provide the inmate number for you during each of your incarceration(s). *Objection*

REQUEST FOR PRODUCTION NO. 1: Please produce all documentary or other physical evidence in your possession which supports or is referenced in your response to Interrogatory No. 4. *DISCOVERY INCOMPLETE*

REQUEST FOR PRODUCTION NO. 2: Please execute and produce the attached Medical Authorization which will allow the attorney for this Defendant to obtain all of your medical records.

REQUEST FOR PRODUCTION NO. 3: Please produce copies of all medical records or other documents concerning your treatment which would support or disprove the allegations contained in your Complaint and Amended Complaint or mitigate any damages. *SEE #1*

REQUEST FOR PRODUCTION NO. 4: Please produce any reports provided by expert witnesses. *SEE #1*

REQUEST FOR PRODUCTION NO. 5: Please produce copies of any chart, graph, document, exhibit and/or any other type of tangible evidence to be displayed, introduced, or relied upon at trial which is not included in your response to the previous request. *SEE #1*

REQUEST FOR PRODUCTION NO. 6: Please produce a copy of the curriculum vitae (resume) of any expert witness you expect to testify at trial on behalf of Plaintiff. *SEE #1*

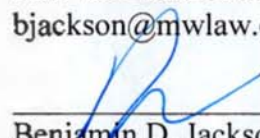
REQUEST FOR PRODUCTION NO. 7: Please produce copies of all of the documents from your prison file in your possession, including but not limited to, grievances or *SEE #1*

complaints filed and documents provided in response, medical request forms or other forms, reports or written requests made during your incarceration.

INTERROGATORY NO. 24: Do you agree to treat the foregoing Interrogatories and Requests for Production of Documents as continuing in nature and supplement your responses thereto upon receipt of any additional information which would alter, amend or supplement these responses? *yes*

Respectfully submitted,

**MITCHELL, WILLIAMS, SELIG,
GATES & WOODYARD, P.L.L.C.**
425 West Capitol Avenue, Suite 1800
Little Rock, AR 72201
Phone: 501-688-8800
Fax: 501-688-8807
bjackson@mwlaw.com


Benjamin D. Jackson (Ark. Bar No. 2006204)

CERTIFICATE OF SERVICE

I, Benjamin D. Jackson, hereby certify that on this 16th day of August, 2018, I have mailed the document by United States Postal Service to the following non CM/ECF participant:

**Frank Carmona Rodriguez
ADC # 40093
Benton County Detention Center
1300 S.W. 14th Street
Bentonville, AR 72712**


Benjamin D. Jackson

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: Frank Rodriguez HEALTH CARE PROVIDER: TurnKey Medical
 DATE OF BIRTH: 8-12-56 SOCIAL SECURITY #: 585-88-2613

1. I authorize the **HEALTH CARE PROVIDER** to make the disclosure of the **PATIENT'S** health information as described below. This authorization is intended to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), HIPAA regulations, and other State and Federal laws and regulations that may create a right of privacy in the health information approved to be disclosed by this authorization.

2. The health information to be disclosed is as follows (dates are included if a limitation to date applies): All nursing home, hospital, physician, nurse, pharmacy, dental, psychiatric, drug treatment, and other healthcare records describing care, treatment, opinions, or services, treatment and therapy records, medication records, prescriptions, diagnostic studies, imaging films, x-rays, monitoring strips, laboratory tests and results, data, charts, admission/transfer sheets (e.g., nursing home, ambulance, hospital), history and physical, discharge summaries, physician orders, all records documenting communications with physician, progress notes, nursing assessments and summaries, evaluations, discharge plans, care plans, (including Minimum Data Sets and Resident Assessment Protocol sheets), care plan meeting notes, nursing notes, decubitus, pressure sore and/or skin reports and audits, drug reviews, nutritional assessments and dietary notes and records, weight records, restorative records, activity records; social service records, physical therapy records, occupational therapy records, speech therapy records, respiratory records, photographs, recordings, administrative records, consents, advance directives, complete billing history/reports/invoices, Medicaid, Medicare, or Veteran's Administration claims, notes, correspondence, consultations, representations made to or by **HEALTH CARE PROVIDER** to third-parties as to the care or treatment provided, or care which could be provided, to **PATIENT**, and any other information pertaining to the treatment and care of **PATIENT'S** injuries, illnesses, and conditions contained in the records of **HEALTH CARE PROVIDER** or any person or agency having responsibility for monitoring the adequacy of care rendered by said **HEALTH CARE PROVIDER**, as well as any and all other records, information, and data relating to **PATIENT'S** health that are in your possession, custody or control. This authorization shall allow the medical provider to engage in discussions concerning my treatment with my counsel or defendant's counsel. The purpose of this medical authorization is to review patient's medical records related to pending litigation.

3. This information may be disclosed to and used by the following individual or organization:
Rainwater, Holt & Sexton, PA, 801 Technology Drive, PO Box 17250, Little Rock, Arkansas 72222.

4. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the **HEALTH CARE PROVIDER**. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event or condition: three (3) years from the date of execution.** I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I further understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR § 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal and state confidentiality rules or 45 CFR § 164.508. Finally, I understand that if I have questions about disclosure of my health information, I can contact my attorneys or the **HEALTH CARE PROVIDER**.

Signature: Frank Rodriguez
 Signature of Patient or Legal Representative

Date: 9-6-18

If signed by Legal Representative, Relationship to Patient

Signature of Witness

2. Defendant #2.

Full Name: Sheriff Holloway & Capt. Guyll
Position: Command Staff
Place of Employment: BCDC
Address: SAME AS ABOVE

3. Defendant #3.

Full Name: Trinity Foods
Position: Food Service
Place of Employment: BCDC
Address: SAME AS ABOVE

4. Defendant #4.

Full Name: Turnkey Medical
Position: Medical Provider
Place of Employment: BCDC
Address: SAME AS ABOVE

If you need more space for additional Defendants, list the additional Defendants on another piece of paper, using the same outline.

V. At the time of the alleged incident(s), were you:
(check the appropriate blank)

X in jail and still awaiting trial on pending criminal charges
serving a sentence as a result of a judgment of conviction
in jail for other reasons (e.g., alleged probation violation, etc.)

Explain: In Jail for Federal Charges

Please provide the date of your conviction or probation or parole revocation:

N/A

If you are asserting an official capacity claim, please describe the custom or policy that you believe caused the violation of your constitutional rights.

SEPARATE PAPER

Claim Number # 2:

Type of Claim (for example, excessive force, denial of medical care, etc.):

Date of the Occurrence:

Name of Each Defendant involved:

Describe the acts or omissions of the Defendant(s) that form the basis for Claim #2 and any harm caused by it.

With regard to Claim #2, are you suing Defendant(s) in his or her: (check the appropriate blank)

☐ official capacity only (An official capacity claim is the same as suing the governmental entity this Defendant works for and requires proof that a custom or policy of the governmental entity caused the alleged violation).

☐ personal capacity only (A personal capacity claim is one that seeks to hold an individual liable for his own actions taken in the course of his duties).

☒ both official and personal capacity

Amended
 FORM TO BE USED BY PRISONERS IN FILING A COMPLAINT
 UNDER THE CIVIL RIGHTS ACT, 42 U.S.C. § 1983

IN THE UNITED STATES DISTRICT COURT
 WESTERN DISTRICT OF ARKANSAS
FAYETTEVILLE DIVISION

FRANK CARMONA RODRIGUEZ
 (Enter above the full name of the Plaintiff
 in this action.)

Prisoner ID No. 40093
 (Do Not Put Your Social Security Number)

v.

CASE NO. 5:18-CV-5118

Deputy IVAN TORRES,
SHERIFF HOLLOWAY, CAPTAIN GUYLL,
JOHN & JANE DUGES, TONY FOODS, TURNKEY MEDICAL, et al
 (Enter above the full name of the Defendant,
 or Defendants, in this action.)

I. Previous Lawsuits

- A. Have you begun other lawsuits in state or federal court dealing with the same facts involved in this action?

Yes _____ No X

- B. If your answer to A is yes, describe each lawsuit in the space below including the exact Plaintiff name or alias used. (If there is more than one lawsuit, describe the additional lawsuits on another piece of paper, using the same outline.)

1. Parties to this lawsuit

Plaintiffs: NONE

Defendants: NONE

2. Court (if federal court, name the district; if state, name the county):

NONE

3. Docket number: NONE

4. Name of judge to whom case was assigned: N/A

5. Disposition (for example: Was the case dismissed? Was it appealed?

Is it still pending?) N/A

6. Approximate date of filing lawsuit: N/A

7. Approximate date of disposition: N/A

(Revised 12/2016)

II. Place of Present Confinement: BCDC, 1300 SW 14TH ST
Bentonville, AR. 72712

III. There is a written prisoner grievance procedure in the Arkansas Department of Correction and in your county jail. Failure to complete the grievance procedure may affect your case in federal court.

A. Did you present the facts relating to your complaint in the state or county written prisoner grievance procedure?

Yes X No

B. If your answer is YES, Attach copies of the most recent written grievance(s)/response(s) relating to your claims showing completion of the grievance procedure. FAILURE TO ATTACH THE REQUIRED COPIES MAY RESULT IN THE DISMISSAL OF YOUR COMPLAINT. If copies are not available, list the number assigned to the grievance(s) and the approximate date it was presented.

C. If your answer is NO, explain why not: GRIEVANCES ON
BCDC Kiosk

IV. Parties

(In item A below, place your name in the first blank and place your present address in the second blank.)

A. Your Full Name: FRANK CARMONA RODRIGUEZ
 Address: 1300 SW 14TH ST
Bentonville, AR. 72712

(In Item B below, place the full name of the defendant in the first blank, his official position in the second blank, his place of employment in the third blank, and his address in the fourth blank.)

Do Not List Witnesses.

You may not name the jail as a Defendant. The jail is a building and cannot be sued.

B. Read carefully and fill out all information sought.

I. Defendant #1

Full Name: IVAN TORRES
 Position: Deputy
 Place of Employment: B.C.D.C.
 Address: 1300 SW 14TH ST
Bentonville, AR. 72712

If you are asserting an official capacity claim, please describe the custom or policy that you believe caused the violation of your constitutional rights.

SEPARATE PAPER

Claim Number #3:

Type of Claim (for example, excessive force, denial of medical care, etc.):

Date of the Occurrence:

Name of Each Defendant involved:

Describe the acts or omissions of the Defendant(s) that form the basis for Claim #3 and any harm caused by it.

With regard to Claim #3, are you suing Defendant(s) in his or her: (check the appropriate blank)

☐ **official capacity only (An official capacity claim is the same as suing the governmental entity this Defendant works for and requires proof that a custom or policy of the governmental entity caused the alleged violation).**

☐ **personal capacity only (A personal capacity claim is one that seeks to hold an individual liable for his own actions taken in the course of his duties).**

☒ **both official and personal capacity**

Received WD/AR

JUN 15 2018

U.S. Clerk's Office

If you are asserting an official capacity claim, please describe the custom or policy that you believe caused the violation of your constitutional rights.

SEPARATE PPR

If you need more space for more claims, list the additional claims on another piece of paper, using the same outline.

VII. Relief

If you are seeking to recover damages from the named Defendants, check the appropriate blank or blanks below for the type or types of damages that you are seeking:

☒ Compensatory damages (designed to compensate persons for injuries, such as physical pain and suffering, etc., that are caused by the deprivation of constitutional rights)

☒ Punitive damages (designed to punish a defendant for engaging in misconduct and deter a defendant and others from engaging in such misconduct in the future)

State briefly below any other relief you are seeking in this action. Make no legal arguments. Cite no cases or statutes.

* JURY TRIAL DEMANDED *

CORRECT DEFICIENCIES IN MEDICAL

CORRECT DEFICIENCIES IN FOOD SERVICE

CORRECT DEFICIENCIES IN TRAINING

OF DEPUTIES

I declare under penalty of perjury (18 U.S.C. § 1621) that the foregoing is true and correct.

Executed this 6 day of June 2018.

6 September

FRANK CARMONA RODRIGUEZ

Signature of Plaintiff

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(This authorization meets the requirements of HIPAA, Section 164.508)

Patient Name: Frank Carmona Rodriguez

Date of Birth: 8-12-56

Social Security No. 585-88-2613

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

Name Turn Key Medical
Address Benton County Jail

3. The type and amount of information to be used or disclosed is as follows:

All medical records, including physicians' records, surgeons' records, x-ray, CAT scans, MRI films, photographs, and any other radiological, nuclear medicine or radiation therapy films, pathology materials, slides, tissues, laboratory reports, discharge summaries, progress notes, consultations, prescriptions, record of drug abuse and alcohol abuse, AIDS diagnosis or treatment, physicals and histories, nurses' notes, patient intake forms, correspondence, psychiatric records, psychological records, social worker's records, insurance records, billing records, administrative records, consent for treatment, examination, periods or stays of hospitalization or confinement, diagnoses, and other information pertaining to and concerning my physical or mental condition to present.

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following organization or its agents for the purpose of a lawsuit.

Mitchell, Williams, Selig, Gates & Woodyard, P.L.L.C.;

Attn: Jamie Montgomery

425 West Capitol Avenue, Suite 1800

Little Rock, AR 72201

This release does not authorize you to discuss any information concerning my treatment by you, without me or my attorney being present. This authorization only allows the above attorney(s) to receive a copy of my chart, x-ray, or other records.

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the medical provider. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in six months. This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof up to and including six months from the date this authorization was executed. This authorization also includes the authority to copy and inspect any and all such reports. A copy of this authorization may be used in place of and with the same force and effect as the original.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the medical provider.

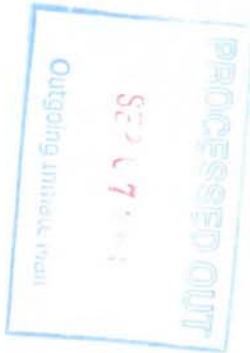
Frank Rodriguez
Signature of Patient or Legal Representative

9-6-18
Date

If Signed by Legal Representative, Relationship to Patient

1300 S.W. 14th St.
Fort Lauderdale, FL

72712



United States District Court
Western District of Oklahoma
Office of the Clerk
35 E. Mountain Ave 510
Fort Lauderdale, FL 72701

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SEP 10 2018
U.S. Clerk's Office



ZIP 72712
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